

Referral for Temporary Assistance through the South Dakota Indigent Medication Program

The Division will use this information to determine eligibility for temporary coverage of laboratory work and psychotropic medications. Please print clearly.

Date: _____ Person assisting with this form/Title: _____

Client Name:

First _____ MI _____ Last _____
Address: _____ Date of Birth: _____

City/State/Zip: _____ Soc. Sec. #: _____

Telephone Number: _____ Sex: Male _____ Female _____

Married _____ Single _____ Widowed _____ Separated _____ # People in household _____

Last hospitalization for mental illness:

Date: _____ Where: _____

Diagnosis: _____

List where you receive your income (including Spouse's income) as well as the \$ amounts:

Are you currently employed? Yes _____ Hrs/week _____ No _____ Volunteer work _____

Yearly Household Income: yourself \$ _____ spouse \$ _____

Do you currently have any Insurance plan that pays for prescription drugs: yes _____ no _____

Supplemental Security Income (check on the first of the month): \$ _____

Soc. Sec. Disability Insurance (check on the 3rd of the month): \$ _____

Do you have Medicare Benefits? Part A _____ Part B _____

Have you applied for a Medicare Part D insurance for your prescriptions? Yes _____ No _____

Pharmacy:

Pharmacy you plan to use _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax (if known): _____

Health care center where lab is to be done:

Name: _____

Address: _____

City/State/Zip: _____ Telephone Number: _____

CMHC: _____

On Waiting List: yes _____ no _____

Drug	Milligrams	Frequency	Can generic be used? Y/N	Why is this medication prescribed?
Lab test needed	How often does this need done?			Why is this test to be done?

I declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature: _____ Date: _____

Return forms (release of information, referral, drug list, and denial notice) to:

Division of Mental Health
Hillsview Properties Plaza
c/o 500 East Capitol
Pierre, South Dakota 57501-5070

Phone: (605)773-5991
Fax: (605)773-7076
1-800-265-9684
Email: Dixie.Erikson@state.sd.us
Tina.Manning@state.sd.us

**DIVISION OF MENTAL HEALTH AUTHORIZATION TO EXCHANGE
INFORMATION**

I hereby authorize the Division of Mental Health to release and/or exchange information both orally and in writing, with respect to diagnosis and course of treatment of my mental illness with any Community Mental Health Center, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.

Consumer/Guardian Signature _____ DATE _____

I acknowledge that the South Dakota Division of Mental Health will pay for my psychotropic medications and/or lab costs on a time-limited basis, as determined by the Division of Mental Health.

I understand the above criteria and the terms/conditions of my participation in the program offered through the Division of Mental Health.

I agree to the following as terms of this medication/laboratory funding agreement:

- **I will take all psychotropic medications as prescribed.**
- **I will be responsible to cover the cost of replacing lost or damaged medications.**
- **I will not sell, give away or otherwise distribute medications intended for personal use.**
- **I will keep all scheduled psychiatric appointments and comply with treatment.**
- **I will develop a plan for long term needs as state funding is limited.**
- **I understand that funding may end with no greater than a 30 day notice.**
- **I will continue to exhaust all other funding resources.**
- **I authorize the exchange/release of relevant and necessary medical/psychiatric information to the Division of Mental Health.**
- **I agree to inform the South Dakota Division of Mental Health if Medicaid or private health insurance is obtained.**
- **I understand that failure to comply with the above-based requirements will result in my termination from the program and/or repayment.**
- **I understand that if this application is not complete or correct, this application will be destroyed.**
- **I understand that this application will be effective one year from the date originally signed.**
- **I understand that I may revoke my consent at any time and that revocation is effective upon receipt, except to the extent previously relied upon.**

Consumer/Guardian Signature _____ DATE _____